Lighthouse Chiropractic

Pediatric Patient Introduction
Ages Newborn to 4 years

Name: _____ Date of Birth ____/____/____

Address: _____ Male / Female

_____ Left Handed / Right handed

Mother' Name: _____ Best Number in which to contact you: _____

Father's Name: _____ Best Number in which to contact you: _____

Home: _____

Email: _____

Emergency Contact (different from parent) _____

Phone: _____

Siblings Names & Ages _____

_____

Consent to Initiate Care

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Please Print Name of Parent/Guardian)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient _____, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given. I agree to pay for all services rendered in this office.

_____

Parent/Guardian Name Parent/Guardian Signature Date

I. General Information

How did you hear of our office?

Business Card Web Search Doctor Friend Fitness Center Event

Who may we thank for referring you? _____

Have you ever been to a Chiropractor before? Yes No

Date of Last visit: _____ Reason for Care: _____

How long were you under care: _____ Were x-rays taken? Yes No

II. Chief Complaint

Reason for seeking Chiropractic Care today: _____

Is issue a result of: Car Accident School Other _____

Have you seen any other doctor for this problem? Yes No Dr. Name _____

List any medications: _____

_____

III. Birth History

Birth Weight: _____ Birth Height: _____

Current Weight: _____ Current Height: _____

Type of Birth: Home Birthing Center Hospital

Normal/Vaginal Forceps Breech Caesarean Suction

Apgar scores: _____ Jaundice (yellow) Yes No

Cyanosis (blue) Yes No

Congenital Anomalies/Defects _____

Infant Feeding: Breast Bottle Formula

Quality of Sleep: Good Fair Poor # of hours of sleep per night: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Last visit Date: _____ Purpose: _____

Immunization History: _____

_____

IV. Childhood History

Research is showing that many of the health challenges that occur later in life have their origins during our developmental years, some starting at birth. Please answer these questions to the best of your ability.

	Yes	No	Details
Did you have any childhood illnesses? (chicken pox, measles, etc.)	____	____	_____
Did you have any serious falls? (tree, seesaw, crib, etc.)	____	____	_____
Did you have any surgeries?	____	____	_____
Prolonged use of medications? (antibiotics, inhalers, etc.)	____	____	_____
Any car accidents?	____	____	_____
Were you under regular Chiropractic care?	____	____	_____
Do you :			
Drink water?	____	____	_____
Consume vitamins or supplements?	____	____	_____

On a scale of Poor, Good, Excellent, describe:

Diet _____ Exercise _____ Sleep _____ General Health _____

V. Wellness Commitment

At Lighthouse Chiropractic, we are dedicated to achieving the goal of total lasting health for our members. To better help you achieve this' we need to understand your commitment to being healthy. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness:

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

VI. Missed Appointment Policy

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week.

In the instance of a no show, we reserve the right to charge you a $20.00 fee. Thank you for your understanding.

Parent/Guardian Name Parent/Guardian Signature Date

Insurance Information (if applicable)

Name of insured _____

Date of Birth _____

Insurance Company _____

Phone # _____

ID # _____

Policy# _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name	Patient Signature	Date
Parent/Guardian Name	Parent/Guardian Signature	Date

Notice of Privacy Practices Acknowledgement
Lighthouse Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Rep Date

Authority of Personal Representative to Sign for Patient (check one):

___ Parent ___ Guardian ___ Power of Attorney _____ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Lighthouse Chiropractic Office Use Only

I tried to obtain written Acknowledgement by individual note above of recipt of our **Notice of Privacy**

___ An emergency prevented us from obtaining acknowledgment

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other: _____

_____ _____

Signature of Personal Representative Date

Medical Information Release Form

(HIPPA Release Form)

_____ _____

Patient's Name (Please Print) Patient's Date of Birth

Release of Information

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ My Insurance Company (only minimum necessary information needed for billing purposes)

_____ Spouse _____
(Name – please print)

_____ Child(re _____
(Name(s) – please print)

_____ Other _____
(Name/relationship – please print)

_____ My information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Signature of Personal Representative Date